



Bureau of Community Health Systems
Division of School Health

REQUEST FOR REIMBURSEMENT AND REPORT OF SCHOOL HEALTH SERVICES FORM

NOTE: This hard copy tally form is for data consolidation only; submit all information electronically in the annual SHARRS report.

SCHOOL YEAR _____

HEALTH DISTRICT	COUNTY	CURRENT VENDOR NUMBER	DENTAL PROGRAM
DOH USE ONLY <input type="checkbox"/> NW <input type="checkbox"/> SW <input type="checkbox"/> NC <input type="checkbox"/> SC <input type="checkbox"/> NE <input type="checkbox"/> SE		DOH USE ONLY	<input type="checkbox"/> MANDATED PROGRAM <input type="checkbox"/> DENTAL HYGIENE SERVICES PROGRAM
EDUCATIONAL INSTITUTION NAME & ADDRESS		INSTITUTION TYPE	
		<input type="checkbox"/> SCHOOL DISTRICT <input type="checkbox"/> CHARTER SCHOOL or <input type="checkbox"/> CYBER CHARTER <input type="checkbox"/> COMPREHENSIVE VO-TECH	
PHONE	PHONE EXTN.	PENN*LINK E-MAIL ADDRESS	

NOTE: *At least one of the following contact persons must be a Certified School Nurse.*

PRIMARY CONTACT PERSON REGARDING REPORT INFORMATION			
NAME (First and Last):			
TITLE:			
PHONE NUMBER (000-000-0000):		EXTN.	
E-MAIL ADDRESS:			

SECONDARY CONTACT PERSON REGARDING REPORT INFORMATION			
NAME (First and Last):			
TITLE:			
PHONE NUMBER (000-000-0000):		EXTN.	
E-MAIL ADDRESS:			

ITEMIZED EXPENDITURES

NOTE: Include expenses: (1) for medical reasons (not academic placement, etc.); (2) fee-for-service costs (not salaries). Do NOT include expenses for sports / athletic programs or expenses reimbursed by Medical Assistance / other insurers.

01. SPECIAL MEDICAL DIAGNOSTIC & TREATMENT SERVICES	TOTAL COST
ENT SPECIALIST / AUDIOLOGIST	\$ _____
OPHTHALMOLOGIST / OPTOMETRIST	\$ _____
OCCUPATIONAL / PHYSICAL THERAPIST	\$ _____
PSYCHIATRIST / PSYCHOLOGIST	\$ _____
OTHER (specify): _____	\$ _____
TOTAL	\$ _____

(Enter total on next page: page 3, section 02, line C. "Special Medical, Diagnostic & Treatment Services".)

02. MEDICAL SUPPLIES, EQUIPMENT, LAB SERVICES & EDUCATIONAL MATERIALS	TOTAL COST
A. ADMINISTRATIVE SUPPLIES	\$ _____
B. FIRST AID / GENERAL SUPPLIES	\$ _____
C. MEDICAL EXAM / HEALTH SCREENING SUPPLIES AND EQUIPMENT	\$ _____
D. REFERENCE AND EDUCATIONAL MATERIALS	\$ _____
TOTAL	\$ _____

(Enter total on next page: page 3, section 02, line D, "Medical Supplies, Equipment, Lab Services & Educational Materials".)

03. SPECIAL DENTAL PREVENTATIVE, DIAGNOSTIC & TREATMENT SERVICES	TOTAL COST
A. PREVENTATIVE	\$ _____
B. DIAGNOSTIC	\$ _____
C. TREATMENT	\$ _____
TOTAL	\$ _____

(Enter total on next page: page 3, section 03, line D "Special Dental Preventative, Diagnostic & Treatment".)

04. DENTAL SUPPLIES, EQUIPMENT, FLUORIDE & EDUCATIONAL MATERIALS	TOTAL COST
A. ADMINISTRATIVE SUPPLIES	\$ _____
B. DENTAL EXAM / SCREENING SUPPLIES & EQUIPMENT / FLUORIDE SUPPLIES	\$ _____
C. REFERENCE AND EDUCATIONAL MATERIALS	\$ _____
TOTAL	\$ _____

(Enter total on next page: page 3, section 03, line E, "Dental Supplies, Equipment, Fluoride & Educational Materials".)

AVERAGE DAILY MEMBERSHIP (ADM) AND COST OF SERVICES

NOTE: Report ADMs to the third decimal point.
 ADMs should match numbers submitted to the
 Department of Education. Do not use enrollment figures.
 (Enter 0.000 on SHARRS report for grades with no ADMs)

01. ADM BY GRADE:

GRADE	PUBLIC STUDENTS	PRIVATE / NON-PUBLIC STUDENTS
K4		
K		
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
UNGRADED SPEC EDUC		
OTHER*		
TOTAL ADM	A.	B.
GRAND TOTAL ADM (Total of Columns A+B above)		

*If other, explanation required:

NOTE: Students attending part-time Vo-Techs should be included in the ADM of each applicable grade. The "Other" category is only for home-schooled and alternative education students. An explanation is required in the comment box.

02. COST OF MEDICAL SERVICES:

NOTE: Salary costs - do not include fringe benefits.

- A. SCHOOL PHYSICIANS \$ _____
- B. SUPPLEMENTAL STAFF \$ _____
- C. SPECIAL MEDICAL, DIAGNOSTIC & TREATMENT SERVICES \$ _____
 (total from page 2, section 01)
- D. MEDICAL SUPPLIES, EQUIPMENT, LAB SERVICES & EDUCATIONAL MATERIALS \$ _____
 (total from page 2, section 02)
- TOTAL** \$ _____

03. COST OF DENTAL SERVICES:

NOTE: Salary costs - do not include fringe benefits.

- A. SCHOOL DENTISTS \$ _____
- B. DENTAL HYGIENISTS \$ _____
- C. DENTAL ASSISTANTS \$ _____
- D. SPECIAL DENTAL PREVENTATIVE, DIAGNOSTIC & TREATMENT SERVICES \$ _____
 (total from page 2, section 03)
- E. DENTAL SUPPLIES, EQUIPMENT, FLUORIDE & EDUCATIONAL MATERIALS \$ _____
 (total from page 2, section 04)
- TOTAL** \$ _____

04. COST OF CERTIFIED SCHOOL NURSING SERVICES:

NOTE: Salary costs - do not include fringe benefits.

- A. CERTIFIED SCHOOL NURSES \$ _____
- B. TRAVEL BETWEEN SCHOOL BUILDINGS \$ _____
- TOTAL** \$ _____

CERTIFIED SCHOOL NURSES (CSN)

CSN Credentials		Assigned School Building(s)	Days per Cycle in Bldg.	As Needed (PRN) or	Students per Building (not ADMs)	Students per CSN (not ADMs)
NOTE: CSNs who job share need to be identified in SHARRS.		NOTE: If PRN, include detailed comment in SHARRS.				
NAME:	Hours/week worked: _____	1. _____	/			
RN: PA License # _____	Expiration date _____	2. _____	/			
CSN: PPID # _____	Expiration date _____	3. _____	/			
<input type="checkbox"/> Emergency Certified : Date Certified _____		4. _____	/			
Additional Credentials: <input type="checkbox"/> Certified RN Practitioner (CRNP) <input type="checkbox"/> Other: _____		5. _____	/			
PA License # _____	Expiration date _____	Total number of students assigned to this CSN at <u>all</u> buildings (Caseload): _____				
NAME :	Hours/week worked: _____	1. _____	/			
RN: PA License # _____	Expiration date _____	2. _____	/			
CSN: PPID # _____	Expiration date _____	3. _____	/			
<input type="checkbox"/> Emergency Certified : Date Certified _____		4. _____	/			
Additional Credentials: <input type="checkbox"/> Certified RN Practitioner (CRNP) <input type="checkbox"/> Other: _____		5. _____	/			
PA License # _____	Expiration date _____	Total number of students assigned to this CSN at <u>all</u> buildings (Caseload): _____				
NAME :	Hours/week worked: _____	1. _____	/			
RN: PA License # _____	Expiration date _____	2. _____	/			
CSN: PPID # _____	Expiration date _____	3. _____	/			
<input type="checkbox"/> Emergency Certified : Date Certified _____		4. _____	/			
Additional Credentials: <input type="checkbox"/> Certified RN Practitioner (CRNP) <input type="checkbox"/> Other: _____		5. _____	/			
PA License # _____	Expiration date _____	Total number of students assigned to this CSN at <u>all</u> buildings (Caseload): _____				
NAME :	Hours/week worked: _____	1. _____	/			
RN: PA License # _____	Expiration date _____	2. _____	/			
CSN: PPID # _____	Expiration date _____	3. _____	/			
<input type="checkbox"/> Emergency Certified : Date Certified _____		4. _____	/			
Additional Credentials: <input type="checkbox"/> Certified RN Practitioner (CRNP) <input type="checkbox"/> Other: _____		5. _____	/			
PA License # _____	Expiration date _____	Total number of students assigned to this CSN at <u>all</u> buildings (Caseload): _____				
NAME :	Hours/week worked: _____	1. _____	/			
RN: PA License # _____	Expiration date _____	2. _____	/			
CSN: PPID # _____	Expiration date _____	3. _____	/			
<input type="checkbox"/> Emergency Certified : Date Certified _____		4. _____	/			
Additional Credentials: <input type="checkbox"/> Certified RN Practitioner (CRNP) <input type="checkbox"/> Other: _____		5. _____	/			
PA License # _____	Expiration date _____	Total number of students assigned to this CSN at <u>all</u> buildings (Caseload): _____				

SUPPLEMENTAL STAFF ASSISTING CSN

Supplemental Staff Credentials		Assigned School Building(s)	CSN Assigned to Students in Building	Function
				Health Care Clerical
NAME:		Hours/week worked: _____	1.	
<input type="checkbox"/> Unlicensed	<input type="checkbox"/> RN <input type="checkbox"/> LPN PA License # _____	Expiration date _____	2.	
	<input type="checkbox"/> CSN: PPID # _____	Expiration date _____	3.	
	<input type="checkbox"/> Emergency Certified: Date Certified _____		4.	
Additional Credentials: <input type="checkbox"/> Certified RN Practitioner (CRNP) <input type="checkbox"/> Other: _____			5.	
PA License # _____		Expiration date _____	<input type="checkbox"/> FLOATING (Non-Permanent Building Assignment)	
NAME:		Hours/week worked: _____	1.	
<input type="checkbox"/> Unlicensed	<input type="checkbox"/> RN <input type="checkbox"/> LPN PA License # _____	Expiration date _____	2.	
	<input type="checkbox"/> CSN: PPID # _____	Expiration date _____	3.	
	<input type="checkbox"/> Emergency Certified: Date Certified _____		4.	
Additional Credentials: <input type="checkbox"/> Certified RN Practitioner (CRNP) <input type="checkbox"/> Other: _____			5.	
PA License # _____		Expiration date _____	<input type="checkbox"/> FLOATING (Non-Permanent Building Assignment)	
NAME :		Hours/week worked: _____	1.	
<input type="checkbox"/> Unlicensed	<input type="checkbox"/> RN <input type="checkbox"/> LPN PA License # _____	Expiration date _____	2.	
	<input type="checkbox"/> CSN: PPID # _____	Expiration date _____	3.	
	<input type="checkbox"/> Emergency Certified: Date Certified _____		4.	
Additional Credentials: <input type="checkbox"/> Certified RN Practitioner (CRNP) <input type="checkbox"/> Other: _____			5.	
PA License # _____		Expiration date _____	<input type="checkbox"/> FLOATING (Non-Permanent Building Assignment)	
NAME:		Hours/week worked: _____	1.	
<input type="checkbox"/> Unlicensed	<input type="checkbox"/> RN <input type="checkbox"/> LPN PA License # _____	Expiration date _____	2.	
	<input type="checkbox"/> CSN: PPID # _____	Expiration date _____	3.	
	<input type="checkbox"/> Emergency Certified: Date Certified _____		4.	
Additional Credentials: <input type="checkbox"/> Certified RN Practitioner (CRNP) <input type="checkbox"/> Other: _____			5.	
PA License # _____		Expiration date _____	<input type="checkbox"/> FLOATING (Non-Permanent Building Assignment)	
NAME:		Hours/week worked: _____	1.	
<input type="checkbox"/> Unlicensed	<input type="checkbox"/> RN <input type="checkbox"/> LPN PA License # _____	Expiration date _____	2.	
	<input type="checkbox"/> CSN: PPID # _____	Expiration date _____	3.	
	<input type="checkbox"/> Emergency Certified: Date Certified _____		4.	
Additional Credentials: <input type="checkbox"/> Certified RN Practitioner (CRNP) <input type="checkbox"/> Other: _____			5.	
PA License # _____		Expiration date _____	<input type="checkbox"/> FLOATING (Non-Permanent Building Assignment)	
NAME:		Hours/week worked: _____	1.	
<input type="checkbox"/> Unlicensed	<input type="checkbox"/> RN <input type="checkbox"/> LPN PA License # _____	Expiration date _____	2.	
	<input type="checkbox"/> CSN: PPID # _____	Expiration date _____	3.	
	<input type="checkbox"/> Emergency Certified: Date Certified _____		4.	
Additional Credentials: <input type="checkbox"/> Certified RN Practitioner (CRNP) <input type="checkbox"/> Other: _____			5.	
PA License # _____		Expiration date _____	<input type="checkbox"/> FLOATING (Non-Permanent Building Assignment)	

OTHER HEALTH PROFESSIONALS

NOTE: Identify the School Physician, the School Dentist, and other health care professionals for credentialing purposes.

- (1) Only a physician (MD [Doctor of Medicine] or a DO [Doctor of Osteopathic Medicine]) can be listed as the School Physician; a CRNP (Certified Registered Nurse Practitioner) and a PA (Physician Assistant) cannot be listed as the School Physician.
- (2) When a group practice is contracted as the School Physician, identify the physician primarily responsible for writing standing medical orders, and the provider(s) primarily performing medical examinations in the school setting. When a group practice is contracted as the School Dentist, identify the dentist primarily responsible for performing dental examinations in the school setting.
- (3) A mobile dentist group may act as the School Dentist as long as they (a) provide services to all students in mandated grades regardless of insurance and (b) the dentist has a valid Pennsylvania license.

NOTE: Schools with approved Dental Hygiene Services Programs should list the program's Dental Hygienists in the section "Dental Hygiene Services Program".

NAME:	
TITLE	Dental Health: <input type="checkbox"/> Dentist <input type="checkbox"/> Dental Clerk/Assistant <input type="checkbox"/> Dental Hygienist (if Dental Hygiene Program, list on page 8) Physical Health: <input type="checkbox"/> Physician (MD; DO) <input type="checkbox"/> Physician Assistant (PA) <input type="checkbox"/> Certified RN Practitioner (CRNP) <input type="checkbox"/> Other _____
Pennsylvania License	<input type="checkbox"/> Unlicensed <input type="checkbox"/> Licensed; Pennsylvania License Number _____ Expiration date _____
Group Practice	<input type="checkbox"/> No <input type="checkbox"/> Yes, Name of Group Practice under agreement to provide in-school exams: _____
Additional PA Licensure	<input type="checkbox"/> N/A <input type="checkbox"/> No <input type="checkbox"/> Yes, if yes, identify credential _____ Pennsylvania License Number _____ Expiration date _____

NAME:	
TITLE	Dental Health: <input type="checkbox"/> Dentist <input type="checkbox"/> Dental Clerk/Assistant <input type="checkbox"/> Dental Hygienist (if Dental Hygiene Program, list on page 8) Physical Health: <input type="checkbox"/> Physician (MD; DO) <input type="checkbox"/> Physician Assistant (PA) <input type="checkbox"/> Certified RN Practitioner (CRNP) <input type="checkbox"/> Other _____
Pennsylvania License	<input type="checkbox"/> Unlicensed <input type="checkbox"/> Licensed; Pennsylvania License Number _____ Expiration date _____
Group Practice	<input type="checkbox"/> No <input type="checkbox"/> Yes, Name of Group Practice under agreement to provide in-school exams: _____
Additional PA Licensure	<input type="checkbox"/> N/A <input type="checkbox"/> No <input type="checkbox"/> Yes, if yes, identify credential _____ Pennsylvania License Number _____ Expiration date _____

NAME:	
TITLE	Dental Health: <input type="checkbox"/> Dentist <input type="checkbox"/> Dental Clerk/Assistant <input type="checkbox"/> Dental Hygienist (if Dental Hygiene Program, list on page 8) Physical Health: <input type="checkbox"/> Physician (MD; DO) <input type="checkbox"/> Physician Assistant (PA) <input type="checkbox"/> Certified RN Practitioner (CRNP) <input type="checkbox"/> Other _____
Pennsylvania License	<input type="checkbox"/> Unlicensed <input type="checkbox"/> Licensed; Pennsylvania License Number _____ Expiration date _____
Group Practice	<input type="checkbox"/> No <input type="checkbox"/> Yes, Name of Group Practice under agreement to provide in-school exams: _____
Additional PA Licensure	<input type="checkbox"/> N/A <input type="checkbox"/> No <input type="checkbox"/> Yes, if yes, identify credential _____ Pennsylvania License Number _____ Expiration date _____

NAME:	
TITLE	Dental Health: <input type="checkbox"/> Dentist <input type="checkbox"/> Dental Clerk/Assistant <input type="checkbox"/> Dental Hygienist (if Dental Hygiene Program, list on page 8) Physical Health: <input type="checkbox"/> Physician (MD; DO) <input type="checkbox"/> Physician Assistant (PA) <input type="checkbox"/> Certified RN Practitioner (CRNP) <input type="checkbox"/> Other _____
Pennsylvania License	<input type="checkbox"/> Unlicensed <input type="checkbox"/> Licensed; Pennsylvania License Number _____ Expiration date _____
Group Practice	<input type="checkbox"/> No <input type="checkbox"/> Yes, Name of Group Practice under agreement to provide in-school exams: _____
Additional PA Licensure	<input type="checkbox"/> N/A <input type="checkbox"/> No <input type="checkbox"/> Yes, if yes, identify credential _____ Pennsylvania License Number _____ Expiration date _____

MANDATED DENTAL SERVICES PROGRAM

DENTAL EXAMINATIONS	PUBLIC STUDENTS	PRIVATE/ NON-PUBLIC STUDENTS	TOTAL STUDENTS
EXAMINED BY FAMILY DENTIST (Include dental examinations performed outside of school setting): A. GRADES K or 1, 3, 7			
EXAMINED BY SCHOOL DENTIST (Include dental examinations performed in school setting or arranged by school, such as mobile dentist): A. GRADES K or 1, 3, 7 B. OTHER GRADES C. REFERRED FOR DENTAL EVALUATION / TREATMENT D. COMPLETED REFERRALS REPORTED			

NOTE: Complete this section if school participates in the fluoride program.

FLUORIDE PROGRAM	PUBLIC STUDENTS	PRIVATE/ NON-PUBLIC STUDENTS	TOTAL STUDENTS
PARTICIPATING IN:			
A. FLUORIDE MOUTH RINSE PROGRAM			
B. FLUORIDE TABLET PROGRAM			
C. TOPICAL FLUORIDE PROGRAM			

DENTAL HYGIENE SERVICES PROGRAM

NOTE: Only schools with a Dental Hygiene Services Program approved by the Department of Health should enter dental-related information in this section of the report.

All other schools should enter dental-related information in the section "Mandated Dental Services Program" and enter the names of dental health professionals in the section "Other Health Professionals."

Certified School Dental Hygienist	
NAME:	Days per School Year Worked: _____
PA Dental Hygiene License # _____	Expiration date _____
PA Dept. of Education Certification: Personal Identification # _____ Expiration date _____	
<input type="checkbox"/> Emergency Certified : Date Certified _____	
Additional Credentials: <input type="checkbox"/> Public Health Dental Hygiene Practitioner (PHDHP) <input type="checkbox"/> Other: _____	
PA License # _____ Expiration date _____	

Certified School Dental Hygienist	
NAME:	Days per School Year Worked: _____
PA Dental Hygiene License # _____	Expiration date _____
PA Dept. of Education Certification: Personal Identification # _____ Expiration date _____	
<input type="checkbox"/> Emergency Certified : Date Certified _____	
Additional Credentials: <input type="checkbox"/> Public Health Dental Hygiene Practitioner (PHDHP) <input type="checkbox"/> Other: _____	
PA License # _____ Expiration date _____	

Certified School Dental Hygienist	
NAME:	Days per School Year Worked: _____
PA Dental Hygiene License # _____	Expiration date _____
PA Dept. of Education Certification: Personal Identification # _____ Expiration date _____	
<input type="checkbox"/> Emergency Certified : Date Certified _____	
Additional Credentials: <input type="checkbox"/> Public Health Dental Hygiene Practitioner (PHDHP) <input type="checkbox"/> Other: _____	
PA License # _____ Expiration date _____	

DENTAL HYGIENE SERVICES PROGRAM (continued)**SERVICES PROVIDED TO** (check all that apply): ☐ Public Students ☐ Private/Non-Public Students

DENTAL EXAMINATIONS / SCREENINGS					
GRADE	EXAMS PERFORMED BY FAMILY DENTIST	EXAMS / SCREENS PERFORMED IN SCHOOL SETTING	RECEIVED PROPHYLAXIS TREATMENT IN SCHOOL SETTING	PARTICIPATED IN PREVENTATIVE DENTAL ACTIVITIES IN SCHOOL	RECEIVED DENTAL HEALTH EDUCATION IN SCHOOL
K4					
K					
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
Ungraded Spec. Ed.					
*OTHER					
TOTAL					

*The "Other" category is only for home-schooled and alternative education students. Students attending part-time Vo-Techs should be included in the ADM of each applicable grade.

DENTAL HYGIENE SERVICES PROGRAM (continued)

STUDENTS EXAMINED / SCREENED IN SCHOOL SETTING	PUBLIC STUDENTS	PRIVATE/ NON-PUBLIC STUDENTS	TOTAL STUDENTS
A. REFERRED FOR FURTHER EVALUATION / TREATMENT			
B. COMPLETED REFERRALS REPORTED			

NOTE: Complete this section if school participates in the fluoride program.

FLUORIDE PROGRAM	PUBLIC STUDENTS	PRIVATE/ NON-PUBLIC STUDENTS	TOTAL STUDENTS
PARTICIPATING IN:			
A. FLUORIDE MOUTH RINSE PROGRAM			
B. FLUORIDE TABLET PROGRAM			
C. TOPICAL FLUORIDE PROGRAM			

HEALTH SERVICES – STAFF / OTHER ADULTS

HEALTH SERVICES FOR STAFF / OTHER ADULTS	STAFF / OTHER ADULTS AT PUBLIC SCHOOL	STAFF / OTHER ADULTS AT PRIVATE/ NON-PUBLIC	TOTAL STAFF / OTHER ADULTS
A. STAFF / OTHER ADULT <u>CONTACTS</u> FOR ACUTE/CHRONIC ILLNESS			
B. STAFF / OTHER ADULT <u>CONTACTS</u> FOR ACUTE/CHRONIC INJURY			
C. STAFF / OTHER ADULT EMERGENCIES REQUIRING ACTIVATION OF EMS SYSTEM			
D. STAFF / OTHER ADULT EMERGENCIES REQUIRING USE OF AN AED			

HEALTH EXAMS, SCREENS & SELECT SERVICES

STUDENT HEALTH SERVICES	PUBLIC STUDENTS	PRIVATE/ NON-PUBLIC STUDENTS	TOTAL STUDENTS
01 STUDENT <u>CONTACTS</u> FOR ACUTE/CHRONIC ILLNESS			
02 STUDENT <u>CONTACTS</u> FOR ACUTE/CHRONIC INJURY			
03 <u>STUDENTS</u> REQUIRING SKILLED NURSING (Total number of students who require skilled nursing procedure ordered by a primary care provider/specialist or deemed necessary by CSN.)			
04 <u>STUDENTS</u> WITH AN IHP, 504 OR IEP WITH A MEDICAL COMPONENT (Total # of students who have a formalized medically necessary plan of care)			
05 <u>STUDENTS</u> SENT FROM SCHOOL FOR HEALTH REASONS			
06 <u>STUDENT</u> EMERGENCIES REQUIRING ACTIVATION OF EMS SYSTEM			
07 <u>STUDENT</u> EMERGENCIES REQUIRING USE OF AN AED			
STUDENT PHYSICAL EXAMINATIONS NOTE: Athletic, work permit & driver's permit physicals are acceptable as a mandated exam, as long as they have not been completed by a chiropractor.	PUBLIC STUDENTS	PRIVATE/ NON-PUBLIC STUDENTS	TOTAL STUDENTS
08 EXAMINED BY FAMILY HEALTH CARE PROVIDER			
A. GRADES K or 1, 6, 11			
09 EXAMINED BY SCHOOL HEALTH CARE PROVIDER			
A. GRADES K or 1, 6, 11			
B. OTHER GRADES			
C. REFERRED FOR FURTHER EVALUATION / TREATMENT			
D. COMPLETED REFERRALS REPORTED			
STUDENT HEALTH SCREENS	PUBLIC STUDENTS	PRIVATE/ NON-PUBLIC STUDENTS	TOTAL STUDENTS
10 VISION SCREENS (K – 12)			
A. REFERRED FOR FURTHER EVALUATION / TREATMENT			
B. COMPLETED REFERRALS REPORTED			
11 HEARING SCREENS (K,1, 2, 3, 7, 11, ungraded special education)			
A. REFERRED FOR FURTHER EVALUATION / TREATMENT			
B. COMPLETED REFERRALS REPORTED			
12 SCOLIOSIS SCREENS (6, 7) NOTE: Students having 6th grade physicals meet requirement for mandated 6th grade scoliosis screen.			
A. REFERRED FOR FURTHER EVALUATION / TREATMENT			
B. COMPLETED REFERRALS REPORTED			
13 GROWTH SCREENS – GRADES K-6			
A. BODY MASS INDEX < 5 TH PERCENTILE			
B. BODY MASS INDEX 5 TH TO 85 TH PERCENTILE			
C. BODY MASS INDEX >85 TH TO < 95 TH PERCENTILE			
D. BODY MASS INDEX ≥ 95 TH PERCENTILE			
14 GROWTH SCREENS- GRADES 7-12			
A. BODY MASS INDEX < 5 TH PERCENTILE			
B. BODY MASS INDEX 5 TH TO 85 TH PERCENTILE			
C. BODY MASS INDEX >85 TH < 95 TH PERCENTILE			
D. BODY MASS INDEX ≥ 95 TH PERCENTILE			

SELECT CHRONIC CONDITIONS – STUDENT HEALTH

CHRONIC CONDITIONS		PUBLIC STUDENTS	PRIVATE/ NON-PUBLIC STUDENTS	TOTAL STUDENTS
01	ARTHRITIS / RHEUMATIC DISEASE			
02	ASTHMA			
03	ATTENTION DEFICIT DISORDER / HYPERACTIVITY			
04	BLEEDING DISORDERS / COOLEY'S ANEMIA			
05	CARDIOVASCULAR CONDITION			
06	CEREBRAL PALSY			
07	CYSTIC FIBROSIS			
08	DIABETES TYPE I			
09	DIABETES TYPE II			
10	EPILEPSY / OTHER SEIZURE DISORDERS			
11	LIFE THREATENING FOOD ALLERGIES			
12	SICKLE CELL DISEASE			
13	SPINA BIFIDA			
14	TOURETTE'S SYNDROME			

SERIOUS SCHOOL INJURIES – STUDENTS

INCLUDE INJURIES TO STUDENT/S IN PUBLIC / PRIVATE SCHOOLS (COMBINED) WHILE UNDER SCHOOL JURISDICTION:

- (1) THAT REQUIRE EMS RESPONSE AND / OR;
- (2) IMMEDIATE CARE BY A PHYSICIAN OR DENTIST AND/OR;
- (3) THE LOSS OF ONE-HALF OR MORE DAYS OF SCHOOL.
- (4) IF MULTIPLE INJURIES TO ONE STUDENT, LIST PRIMARY INJURY ONLY.
- (5) ENTER ONE ENTRY FOR EACH CATEGORY.

NOTE: DO NOT INCLUDE SPORTS INJURIES OCCURRING DURING APPROVED INTERSCHOLASTIC ATHLETIC ACTIVITIES.

NOTE: THE TOTAL OF EACH SUBSECTION (NATURE OF INJURY, TIME PERIOD, AND LOCATION) SHOULD EQUAL ONE ANOTHER.

NATURE OF INJURY					
01 BURN		05 DENTAL INJURY		09 SPRAIN / STRAIN / TEAR (POSSIBLE)	
02 CONCUSSION (POSSIBLE)		06 DISLOCATION (POSSIBLE)		10 OTHER	
03 CONTUSION		07 EYE INJURY		TOTAL OF SUBSECTION: NATURE OF INJURY	
04 CUT / LACERATION / PUNCTURE		08 FRACTURE (POSSIBLE)			

TIME PERIOD					
01 AFTER SCHOOL		05 FIELD TRIP		09 SCI LAB / FAM & CONSUMER SCI & TECH ED CLASS	
02 BEFORE SCHOOL		06 LUNCH PERIOD		10 OTHER	
03 CLASS CHANGE		07 P. E.		TOTAL OF SUBSECTION: TIME PERIOD	
04 CLASS TIME		08 RECESS			

LOCATION					
01 ATHLETIC FIELD / PLAY FIELD		07 FIELD TRIP		13 SIDEWALK	
02 AUDITORIUM / MULTIPURPOSE		08 GYMNASIUM / POOL		14 STAIRS / RAMP / ELEVATOR	
03 BUS LOADING AREA		09 PLAYGROUND		15 STREET / DRIVEWAY / PARKING	
04 CAFETERIA		10 RESTROOM		16 OTHER	
05 CLASSROOM		11 SCHOOL BUS / PUBLIC BUS		TOTAL OF SUBSECTION: LOCATION	
06 CORRIDOR / HALL		12 SCI LAB / FAM & CONSUMER SCI & TECH ED CLASS			

MEDICATION ADMINISTRATION – STUDENTS

NOTE: Medications should be counted under their FDA Classification, not by category of use.

MEDICATION	NUMBER OF DOSES ADMINISTERED	
	DOSES BY INDIVIDUAL ORDER	DOSES BY STANDING ORDER (School Physician)
01 ANALGESIC	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
02 ANTIBIOTIC	<input style="width: 100%;" type="text"/>	NOTE: TOPICAL ANTIBIOTICS ONLY
03 ANTICONVULSANTS		
A. DIASTAT	<input style="width: 100%;" type="text"/>	
B. VERSED	<input style="width: 100%;" type="text"/>	
C. OTHER THAN DIASTAT OR VERSED	<input style="width: 100%;" type="text"/>	
04 ANTIHISTAMINE / DECONGESTANT		
A. EPINEPHRINE / EPI-PEN	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
B. OTHER THAN EPINEPHRINE / EPI-PEN	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
05 ANTI-INFLAMMATORY	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
06 ASTHMATIC (INCLUDE INHALANT, NEBULIZER, ORAL)	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
07 DIABETIC		
A. ORAL	<input style="width: 100%;" type="text"/>	
B. INSULIN (INCLUDE INSULIN PUMP)	<input style="width: 100%;" type="text"/>	
C. GLUCAGON	<input style="width: 100%;" type="text"/>	
D. OTHER GLUCOSE MEDS (GEL, TABS)	<input style="width: 100%;" type="text"/>	
08 GASTROINTESTINAL		
A. ENZYMES	<input style="width: 100%;" type="text"/>	
B. OTHER THAN ENZYMES	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
09 PSYCHOTROPIC		
A. ADD / ADHD	<input style="width: 100%;" type="text"/>	
B. OTHER THAN ADD / ADHD	<input style="width: 100%;" type="text"/>	
10 OTHER (EXCLUDE COUGH DROPS & THROAT LOZENGES)	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
TOTAL	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>